## AMAP NOTIFICATION CHANGE FORM

This form is to notify the **appropriate** OHFLAC program when one of the following occurs:

1) AMAP withdrawal of privileges to administer medications.
2) Facility policies and procedure changes.

### 1. Facility – Policy and Procedure Changes

☐ AMAP policy and procedure ***(please attach a copy of the revisions for approval)***

Facility Name: _____ Address: _____

Facility type:

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| ICF/IID: | ☐ | ☐ | Assisted Living: | ☐ | ☐ | | | |
| Adult family care (AFC): | ☐ | ☐ | Behavioral Health: | ☐ | ☐ | Private Residence: | ☐ | ☐ |

FOR **BEHAVIORAL HEALTH FACILITY** TYPE, MAIL OR FAX THIS FORM TO THE PROGRAM LISTED BELOW:

**ATTENTION: JAMES COOPER, PROGRAM MANAGER II**
OHFLAC – BEHAVIORAL HEALTH PROGRAM
408 LEON SULLIVAN WAY
CHARLESTON, WV 25301-1713
FAX: 304.558.2515

FOR **ASSISTED LIVING,** OR **PERSONAL CARE** FACILITY TYPE, MAIL OR FAX THIS FORM TO THE PROGRAM LISTED BELOW:

**ATTENTION: SHARON KIRK, NURSING DIRECTOR II**
OHFLAC – ASSISTED LIVING PROGRAM
408 LEON SULLIVAN WAY
CHARLESTON, WV 25301-1713
FAX: 304.558.2515

### 2. AMAP - Privileges Changes

_____ _____

*AMAP name:* *AMAP – Birth Date (MM /DD /YYYY):*

*Specific Reason(s) for withdrawal of privileges:* _____

☐ Privileges withdrawn ***(*Please *attach a copy of the RN's withdrawal letter that notifies the AMAP that their privileges were withdrawn*)**

For AMAP privilege changes, submit this form to the program listed below:

OHFLAC – AMAP-RN ORIENTATION
408 Leon Sullivan way
Charleston, WV 25301-1713
FAX: 304.558.2515
**ATTENTION: AMAP-RN ORIENTATION/NA PROGRAM**

Facility name _____

RN name: _____ RN License # _____ **Date:** _____

RN signature required